STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155218	A. BUILDING 00 B. WING	07/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY PLACE OF DYER	2300 GREAT LAKES DRIVE DYER, IN46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00093712. Complaint IN00093712 substantiated, Federal/State deficiencies related to the allegations are cited at F 225, F 226, F 272, and F 323. Unrelated deficiencies cited. Survey dates: July 27 and 28, 2011 Facility number: 000123 Provider number: 155218 AIM number: 100266720 Survey team: Janelyn Kulik, RN Census bed type: SNF/NF: 136 Total: 136 Census payor type: Medicare: 28 Medicaid: 83 Other: 25 Total: 136 Sample: 8 These deficiencies also reflect state	F0000	The facility requests that this plan of correction be considered its credible allegations of compliance. Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Administrator, or any employee, agents, or other individuals who draft or may be discussed in the response and Plan of Correction. In addition, preparation and submission of the Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of a conclusion set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of appeal of this matter solely because of the requirements under State and Federal law that mandates submission of the Plan of Corrections a condition to	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	findings cited in accordance with 410 IAC 16.2. Quality review completed 8/1/11 Cathy Emswiller RN		participate in the Title 18 and Title 19 programs. The submission of Plan of Correction within this timeframe should in no way be of non-compliance or admission by the facility.	

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F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview the facility failed to ensure every suspected allegation of abuse was reported promptly to the Administrator or the Director of Nursing for 1 of 3 allegations of abuse	F0225	**F – 225** It is the practice of this facility to ensure the highest quality of care is afforded our residents.	08/19/2011

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	reviewed in a sample of 8. (Resident #B) Findings include: The record for Resident #B was reviewed on 7/28/11 at 9:25 a.m. The resident's diagnoses included, but were not limited to, lymphoma, pneumonia, anemia, and hypertension. A nursing note dated 6/16/11 at 2:00 p.m., indicated Social Service #1 followed up with the resident for emotional distress. The resident denied distress. The resident continued to stated, "The CNA took (sic) care of me.(sic) I do not want her in any trouble." Res (Resident) was reassured staff member and administration was going through the proper measures to address this matter. The resident was encouraged to focus on her health and getting better. The staff will continue to monitor. A reportable incident with investigation was provided by the Administrator and reviewed on 7/28/11 at 12:00 p.m. The initial fax cover sheet was dated 6/16/11. The incident was not dated. The incident indicated Resident #B told a therapist that over the weekend a staff member was loud with her. She identified the staff member as CNA #3. "After investigation, it was found the		Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was: **Upon receipt of the information, facility administration immediately began investigation related to Res. B's allegation. C.N.A. #3 is no longer employed at this facility. C.N.A. #2 has been counseled on timely reporting of abuse allegations.** The corrective action taken for those residents having the potential to be affected by the same deficient practice is: **Interviewable residents were asked if they had any issues related to abuse and customer service. No other issues were identified through this process.** The measures put into place and systemic change made to ensure the deficient practice does not recur is: **Facility staff has been re-educated by the ED and**	

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	above CNA was trying to find someone to help her with (Resident #B's name) care needs at the time, so (Resident #B's name) waited longer than usual to get the care she needed. (Resident #B's name) confirmed that she was frustrated with the CNA when she came back into the room, but stated that the CNA also had an attitude regarding having to care for her. Although facility was able to conclude that abuse did not occur, (CNA #3's name) was written up for customer service related issues due to this concern. (CNA #3's name) was already on a final written warning unrelated to these issues, so this write up resulted in her termination from the facility. An Alleged Abuse, Neglect and Exploitation Investigation worksheet provided in the investigation, indicated "Res (resident) states her call light was on CNA answered. Res (resident) informed CNA she need (sic) to be changed. CNA fearful (sic) r/t (related to) res (resident) having trach (tracheotomy). States she (sic) going to find (sic) CNA who is familiar with her. 10 min (minutes) later call (sic) light back on CNA (sic) returned. Res (resident) asked if she found the other CNA. Staff CNA yelled just forget it I will do it myself. Res (resident) refused CNA (sic) to touch her. CNA returned to the room shortly and		**Nursing Administration related to timely response to and method of reporting abuse allegations. Department managers are conducting daily interviews with residents to ensure resident needs are being met. Any issues are immediately addressed.** To ensure the deficient practice does not recur, the monitoring system established is: **A Performance Improvement tool has been developed that evaluates timely reporting for allegations of abuse. Department Mangers to complete tool twice weekly on interviewable residents and present results at daily clinical meeting to ensure timely resolution when necessary. These results will be reviewed at the monthly PI meeting ongoing per facility protocol.**	

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	stated she was sorry and explained she was fearful she would hurt her d/t (due to) the trach (tracheotomy). Res (resident) accept (sic) the apology and fell (sic) the incident was both their fault (sic). It was a simple misunderstanding." The incident took place in the resident's room. The victim was Resident #B. The perpetrator was CNA #3. A memo to the Administrator dated 6/15/11, indicated "Pt. (patient) stated she doesn't want to bother anyone because one time she hit her call light twice and that (sic) the CNA, came in and yelled at her, pt (patient) stated she/pt (patient)got very upset and wanted to report the CNA, pt (patient) stated the CNA #2 came into her room to clam her down and "begged" pt (patient) not to report the CNA. This therapist spoke with case manager." The resident indicated this happened this last Thursday or Friday. A written statement from CNA #3, indicated the resident's light was on and the resident indicated she needed to be changed. CNA #3 told the resident she needed to get CNA #2. The resident put her light on. I went back in the room and the resident "said again - I need to be changed." I told her I needed to get CNA #2 because I didn't know how to take care of her. "Resident stated, I need to be			

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	changed now." CNA left the room got CNA #2 and they took care of her needs. A written statement from CNA #2, indicated he did not report what had happened because he thought everything was fine between CNA #3 and Resident #B. Interview with the Administrator on 7/28/11 at 12:30 p.m., indicated CNA #2 knew of the incident between CNA #3 and Resident #B and did not report the incident. He has been educated to report all incidents. This Federal tag relates to complaint IN00093712. 3.1-28(c)			
F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview the facility failed to ensure the facility followed its abuse policy regarding reporting all allegations of abuse immediately to the Administrator or the Director of Nursing for 1 of 3 allegations	F0226	**F – 226** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done:	08/19/2011

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	of abuse reviewed in a sample of 8. (Resident #B) Findings include: The record for Resident #B was reviewed on 7/28/11 at 9:25 a.m. The resident's diagnoses included, but were not limited to, lymphoma, pneumonia, anemia, and hypertension. A nursing note dated 6/16/11 at 2:00 p.m., indicated Social Service #1 followed up with the resident for emotional distress. The resident denied distress. The resident continued to stated, "The CNA took (sic) care of me.(sic) I do not want her in any trouble." Res (Resident) was reassured staff member and administration was going through the proper measures to address this matter. The resident was encouraged to focus on her health and getting better. The staff will continue to monitor. A reportable incident with investigation was provided by the Administrator and reviewed on 7/28/11 at 12:00 p.m. The initial fax cover sheet was dated 6/16/11. The incident was not dated. The incident indicated Resident #B told a therapist that over the weekend a staff member was loud with her. She identified the staff member as CNA #3.		The corrective action taken for the residents found to have been affected by the deficient practice was: **Upon receipt of the information, facility administration immediately began investigation related to Res. B's allegation. C.N.A. #3 is no longer employed at this facility. C.N.A. #2 has been counseled on timely reporting of abuse allegations** The corrective action taken for those residents having the potential to be affected by the same deficient practice is: **Interviewable residents were asked if they had any issues related to abuse and customer service. No other issues were identified through this process.** The measures put into place and systemic change made to ensure the deficient practice does not recur is: **Facility staff has been re-educated by the ED and Nursing Administration related to timely response to and method of reporting abuse allegations. Department managers are conducting daily interviews with residents to**	

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	"After investigation, it was found the above CNA was trying to find someone to help her with (Resident #B's name) care needs at the time, so (Resident #B's name) waited longer than usual to get the care she needed. (Resident #B's name) confirmed that she was frustrated with the CNA when she came back into the room, but stated that the CNA also had an attitude regarding having to care for her. Although facility was able to conclude that abuse did not occur, (CNA #3's name) was written up for customer service related issues due to this concern. (CNA #3's name) was already on a final written warning unrelated to these issues, so this write up resulted in her termination from the facility. An Alleged Abuse, Neglect and Exploitation Investigation worksheet provided in the investigation, indicated "Res (resident) states her call light was on CNA answered. Res (resident) informed CNA she need (sic) to be changed. CNA fearful (sic) r/t (related to) res (resident) having trach (tracheotomy). States she (sic) going to find (sic) CNA who is familiar with her. 10 min (minutes) later call (sic) light back on CNA (sic) returned. Res (resident) asked if she found the other CNA. Staff CNA yelled just forget it I will do it myself. Res (resident) refused CNA (sic) to touch her.		**ensure resident needs are being met. Any issues are immediately addressed.** To ensure the deficient practice does not recur, the monitoring system established is: **A Performance Improvement tool has been developed that evaluates timely reporting for allegations of abuse. Department Mangers to complete tool twice weekly on interviewable residents and present results at daily clinical meeting to ensure timely resolution when necessary. These results will be reviewed at the monthly PI meeting ongoing per facility protocol.**	

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	CNA returned to the room shortly and stated she was sorry and explained she was fearful she would hurt her d/t (due to) the trach (tracheotomy). Res (resident) accept (sic) the apology and fell (sic) the incident was both their fault (sic). It was a simple misunderstanding." The incident took place in the resident's room. The victim was Resident #B. The perpetrator was CNA #3. A memo to the Administrator dated 6/15/11, indicated "Pt. (patient) stated she doesn't want to bother anyone because one time she hit her call light twice and that (sic) the CNA, came in and yelled at her, pt (patient) stated she/pt (patient)got very upset and wanted to report the CNA, pt (patient) stated the CNA #2 came into her room to clam her down and "begged" pt (patient) not to report the CNA. This therapist spoke with case manager." The resident indicated this happened this last Thursday or Friday. A written statement from CNA #3, indicated the resident's light was on and the resident indicated she needed to be changed. CNA #3 told the resident she needed to get CNA #2. The resident put her light on. I went back in the room and the resident "said again - I need to be changed." I told her I needed to get CNA #2 because I didn't know how to take care			

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of her. "Resident stated, I need to be changed now." CNA left the room got CNA #2 and they took care of her needs.

A written statement from CNA #2, indicated he did not report what had happened because he thought everything was fine between CNA #3 and Resident #B.

The Abuse Policy was provided by the Administrator on 7/27/11 at 9:30 a.m. Policy: "Verbal, sexual, physical, and mental abuse corporal punishment, involuntary seclusion, and neglect of the resident as well as mistreatment, neglect, and misappropriation of resident property are strictly prohibited.
Responding to the and Investigating an Abuse Allegation procedure included, but was not limited to, "Contact the Executive Director and Director of Nursing immediately.

Interview with the Administrator on 7/28/11 at 12:30 p.m., indicated CNA #2 knew of the incident between CNA #3 and Resident #B and did not report the incident. He has been educated to report all incidents.

This Federal tag relates to complaint IN00093712.

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	3.1-28(a)			
F0272 SS=D	The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. Based on record review and interview the facility failed to ensure an assessment was completed after a fall for 1 of 3 residents review for falls in a sample of 8 related to a resident falling and complaining of a	F0272	**F – 272** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the	08/19/2011

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	broken leg and the resident being moved. (Resident #H) Findings include: The record for Resident #H was reviewed on 7/27/11 at 11:30 a.m. The resident's diagnoses included, but was not limited to, dementia, urinary tract infection, right hip fracture, dehydration, glaucoma, hypertension, depression, and osteopenia (weak bones). A nursing note dated 7/11/11 at 12:28 a.m., indicated the nurse was called to the resident's room by the CNA. The resident was observed lying on the floor next to the bathroom door. The resident indicated she was going to the bathroom. The resident was assessed while on the floor. There were no deformities or discoloration noted. The resident complained of slight pain to the right femur (upper leg). On a scale of 1 to 10 her pain was 4. The resident was assisted to the wheelchair and then to bed where she was further assessed. The resident had no leg deformities or discoloration and was able to bear slight weight. The resident complained of pain at a level of 6 on a scale of 1-10. An order was received for an x-ray of the right leg to rule out a fracture and the resident was to be on bed rest until the x-ray results were obtained.		following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was: **Res. H returned to the facility 7/15/11. Nurse #1 is no longer employed by the facility.** The corrective action taken for those residents having the potential to be affected by the same deficient practice is: **Facility conducted an audit of the past 30 days of falls to ensure proper assessment and follow through was completed per facility standards. No issues with assessment were identified.** The measures put into place and systemic change made to ensure the deficient practice does not recur is: **Licensed staff have been re-educated on process to follow post resident fall. Education to include physical assessment, family and MD notification and immediate intervention implement towards prevention of future occurrence. A "Quick Guide to Falls" has been posted at each**	

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	The resident will continue to be monitored for pain. Pain medication was given. A nursing note dated 7/11/11 at 6:30 a.m., indicated the resident was reassessed and noted to have a rotated right hip. The resident's pain was 7 on a scale of 1-10. The nurse practitioner was called and made aware of the right leg being externally rotated out and the right leg being shorter than the other leg. An order was received for the resident to be sent to the hospital for evaluation and treatment. A nursing note dated 7/11/11 at 3:35 p.m., indicated late entry for 7/11/11 at 6:30 a.m.. The nurse arrived and received report from the night nurse that the resident fell during the night and had slight pain and received Tylenol (pain medication); The nurse did rounds and noticed resident in pain and right leg rotated outwards and painful to touch or bend. The nurse called the nurse practitioner and explained what the nurse had assessed. An order was received to send the resident to the emergency room for evaluation and treatment. A hospital History and Physical dated 7/14/11, indicated the resident was admitted on 7/11/11. The History of Present Illness: The patient "was		**nurse's station as a visual reminder of this education.** To ensure the deficient practice does not recur, the monitoring system established is: **A Performance Improvement tool has been developed that will monitor that proper post fall assessments have been conducted properly in accordance with facility policy. The DNS or Designee will complete PI tools weekly for four weeks, monthly for a quarter and quarterly thereafter with results being forwarded to the PI committee for further review until 100% compliance is achieved.**	

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	155218	A. BUILDING 00 B. WING	07/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY PLACE OF DYER	2300 GREAT LAKES DRIVE DYER, IN46311

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	admitted to the hospital through the Emergency Room after undergoing a fall on the evening of admission while she went to turn around and had subsequently lost her balance. The patient subsequently fell and at this time did develop a comminuted intertrochanteric fracture of the right hip (right hip fracture). A post fall evaluation indicated the date of the fall was 7/11/11 at 12:30 a.m. and completed by Nurse #1. The fall was unwitnessed. There was no injury noted at the time of the fall. An x-ray was ordered to rule out a fracture. The resident was rechecked and discoloration was noted to the resident's right hip. An order was received to send the resident to the hospital. The investigation of the fall was provided by the Administrator on 7/27/11 and reviewed at 3:00 p.m. A typed interview dated 7/13/11 with CNA #1 regarding the events of 7/11/11 and fall of Resident #H, indicated, "I had the assignment that included (Resident #H's name). At about 12:20-12:30 a.m., I noticed the door to her room was closed. When I tried to enter, I discovered the resident sitting on the floor with her back against the closed bathroom door. I called to the nurse to help. When (Nurse #1's name) came into the room, he tried to get the resident to stand up and			

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	walk to her bed, but she said, "no, "I can't stand, my leg is broken." He argued with her and said that it wasn't broken. Then we both got her into the wheelchair. I then got her to bed by standing her from the w/c (wheelchair) and quickly pivoting her on her (unaffected) leg. I remember that she was just a one-person, minimal assist on South unit-she was able to stand and walk and was almost independent with it, so I knew she had changed. She wasn't crying, but said that it hurt really bad. I think (Nurse #1's name) gave her some medication. I went back in to check on her at (sic) at between 2:30 and 3:00, and changed her brief. She said it still hurt her, so I didn't turn her very far, but was able to get it changed. I don't remember seeing (Nurse #1's name) go back into the room during my shift." A performance Improvement Form dated 7/11/11 for Nurse #1 indicated the reason for the counseling/corrective action was the neglect to monitor resident with significant injury from fall despite giving Tylenol shortly after the fall. The documentation was inconsistent on Neuro check relative to injury sustained. The documentation was incomplete related to pain and non sequential negligence is evident. Interview with the Administrator on			

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	7/28/11 at 12:30 p.m., indicated she did not know if the alarm was on when the Resident #H fell. She also indicated due to the interview with CNA #1 there was concern the resident had not been assessed prior to being moved. She further indicated CNA #2 had told management the resident had informed Nurse #1 he leg was broken prior to the resident being moved. She also indicated due to the discrepancy in the nurse's documentation it was felt the resident had not been assessed properly after the resident's fall. The nurse was terminated for this and other issues. This Federal tag relates to complaint IN00093712. 3.1-31(c)(1)			
F0281 SS=D	The services provided or arranged by the facility must meet professional standards of quality. Based on record review and interview the facility failed to ensure professional standards of quality were met related to a Licensed Practical Nurse (LPN) not assessing a resident for 1 or 3 residents	F0281	**F – 281** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the	08/19/2011

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	reviewed for falls in a sample of 8 related to a resident falling and complaining of a broken leg and the resident being moved. (Resident #H) Findings include: The record for Resident #H was reviewed on 7/27/11 at 11:30 a.m. The resident's diagnoses included, but was not limited to, dementia, urinary tract infection, right hip fracture, dehydration, glaucoma, hypertension, depression, and osteopenia (weak bones). A nursing note dated 7/11/11 at 12:28 a.m., indicated the nurse was called to the resident's room by the CNA. The resident was observed lying on the floor next to the bathroom door. The resident indicated she was going to the bathroom. The resident was assessed while on the floor. There were no deformities or discoloration noted. The resident complained of slight pain to the right femur (upper leg). On a scale of 1 to 10 her pain was 4. The resident was assisted to the wheelchair and then to bed where she was further assessed. The resident had no leg deformities or discoloration and was able to bear slight weight. The resident complained of pain at a level of 6 on a scale of 1-10. An order was received for an x-ray of the right leg to rule out a		following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was: **Res. H returned to the facility 7/15/11. Nurse #1 is no longer employed by the facility.** The corrective action taken for those residents having the potential to be affected by the same deficient practice is: **Facility conducted an audit of the past 30 days of resident falls to ensure proper assessment and follow through was completed per facility standards. No issues with assessment were identified** The measures put into place and systemic change made to ensure the deficient practice does not recur is: **Licensed staff have been re-educated on process to follow post resident fall. Education to include physical assessment, family and MD notification and immediate intervention implement towards prevention of future occurrence. A "Quick Guide to**	

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	fracture and the resident was to be on bed rest until the x-ray results were obtained. The resident will continue to be monitored for pain. Pain medication was given. A nursing note dated 7/11/11 at 6:30 a.m., indicated the resident was reassessed and noted to have a rotated right hip. The resident's pain was 7 on a scale of 1-10. The nurse practitioner was called and made aware of the right leg being externally rotated out and the right leg being shorter than the other leg. An order was received for the resident to be sent to the hospital for evaluation and treatment. A nursing note dated 7/11/11 at 3:35 p.m., indicated late entry for 7/11/11 at 6:30 a.m.. The nurse arrived and received report from the night nurse that the resident fell during the night and had slight pain and received Tylenol (pain medication); The nurse did rounds and noticed resident in pain and right leg rotated outwards and painful to touch or bend. The nurse called the nurse practitioner and explained what the nurse had assessed. An order was received to send the resident to the emergency room for evaluation and treatment. A hospital History and Physical dated 7/14/11, indicated the resident was		**Falls" has been posted at each nurse's station as a visual reminder of this education.** To ensure the deficient practice does not recur, the monitoring system established is: **A Performance Improvement tool has been developed that will monitor that proper post fall assessments have been conducted properly in accordance with facility policy. The DNS or Designee will complete PI tools weekly for four weeks, monthly for a quarter and quarterly thereafter with results being forwarded to the PI committee for further review until 100% compliance is achieved.**	

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	admitted on 7/11/11. The History of Present Illness: The patient "was admitted to the hospital through the Emergency Room after undergoing a fall on the evening of admission while she went to turn around and had subsequently lost her balance. The patient subsequently fell and at this time did develop a comminuted intertrochanteric fracture of the right hip (right hip fracture). A post fall evaluation indicated the date of the fall was 7/11/11 at 12:30 a.m. and completed by Nurse #1. The fall was unwitnessed. There was no injury noted at the time of the fall. An x-ray was ordered to rule out a fracture. The resident was rechecked and discoloration was noted to the resident's right hip. An order was received to send the resident to the hospital. Review of the Indiana State Board of Nursing: A compilation of the Indiana Code and Indiana Administrative Code retrieved on 7/30/11 from www. PLA.IN.gov, indicated The licensed practical nurse shall do the following which include, but was not limited to, "Know and utilize the nursing process in planning, implementing, and evaluating health services and nursing care to the individual patient or client." "Assess the health status of the patient/client, in			

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	conjunction with other members of the health care team, for analysis and identification of health goals." "Evaluate with the patient/client the status of goal achievement as a basis for reassessment, reordering of priorities, and new goals setting for contribution to the modification of the plan of care." The investigation of the fall was provided by the Administrator on 7/27/11 and reviewed at 3:00 p.m. A typed interview dated 7/13/11 with CNA #1 regarding the events of 7/11/11 and fall of Resident #H, indicated, "I had the assignment that included (Resident #H's name). At about 12:20-12:30 a.m., I noticed the door to her room was closed. When I tried to enter, I discovered the resident sitting on the floor with her back against the closed bathroom door. I called to the nurse to help. When (Nurse #1's name) came into the room, he tried to get the resident to stand up and walk to her bed, but she said, "no, "I can't stand, my leg is broken." He argued with her and said that it wasn't broken. Then we both got her into the wheelchair. I then got her to bed by standing her from the w/c (wheelchair) and quickly pivoting her on her (unaffected) leg. I remember that she was just a one-person, minimal assist on South unit-she was able to stand and walk and was almost independent with it, so I knew she had changed. She			

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wasn't crying, but said that it hurt really bad. I think (Nurse #1's name) gave her some medication. I went back in to check on her at (sic) at between 2:30 and 3:00, and changed her brief. She said it still hurt her, so I didn't turn her very far, but was able to get it changed. I don't remember seeing (Nurse #1's name) go back into the room during my shift."

A performance Improvement Form dated 7/11/11 for Nurse #1 indicated the reason for the counseling/corrective action was the neglect to monitor resident with significant injury from fall despite giving Tylenol shortly after the fall. The documentation was inconsistent on Neuro check relative to injury sustained. The documentation was incomplete related to pain and non sequential negligence is evident.

Interview with the Administrator on 7/28/11 at 12:30 p.m., indicated she did not know if the alarm was on when the Resident #H fell. She also indicated due to the interview with CNA #1 there was concern the resident had not been assessed prior to being moved. She further indicated CNA #2 had told management the resident had informed Nurse #1 he leg was broken prior to the resident being moved. She also indicated due to the discrepancy in the nurse's

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	documentation it was felt the resident had not been assessed properly after the resident's fall. The nurse was terminated for this and other issues. This Federal tag relates to complaint IN00093712. 3.1-35(g)(1)			
F0323 SS=G	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview the facility failed to ensure fall interventions were in place, assessments completed after a fall for 2 of 3 residents review for falls in a sample of 8 related to an alarm not being in place and the resident not assessed after a fall, resulting in the resident going to the hospital with a fractured right hip (Resident #H) and a resident being transferred by one staff member using the hoyer (mechanical) lift. (Resident #E) Findings include: 1. The record for Resident #H was reviewed on 7/27/11 at 11:30 a.m. The resident's diagnoses included, but was not	F0323	**F – 323** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was: **Res. H returned to the facility 7/15/11. Res. E returned to the facility on7/11/11.** The corrective action taken for those residents having the	08/19/2011

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	limited to, dementia, urinary tract infection, right hip fracture, dehydration, glaucoma, hypertension, depression, and osteopenia (weak bones). A nursing note dated 7/11/11 at 12:28 a.m., indicated the nurse was called to the resident's room by the CNA. The resident was observed lying on the floor next to the bathroom door. The resident indicated she was going to the bathroom. The resident was assessed while on the floor. There were no deformities or discoloration noted. The resident complained of slight pain to the right femur (upper leg). On a scale of 1 to 10 her pain was 4. The resident was assisted to the wheelchair and then to bed where she was further assessed. The resident had no leg deformities or discoloration and was able to bear slight weight. The resident complained of pain at a level of 6 on a scale of 1-10. An order was received for an x-ray of the right leg to rule out a fracture and the resident was to be on bed rest until the x-ray results were obtained. The resident will continue to be monitored for pain. Pain medication was given. A nursing note dated 7/11/11 at 6:30 a.m., indicated the resident was reassessed and noted to have a rotated right hip. The resident's pain was 7 on a scale of 1-10.		potential to be affected by the same deficient practice is: **Full facility audit was done to ensure that preventative measures put in place for the prevention of falls were in place as indicated. Issues were immediately addressed and additional assessment completed as necessary. A full facility audit was also completed to ensure the proper mode of transfer for each resident is reflected on the current C.N.A. assignment sheet.** **Facility conducted an audit of the past 30 days of falls to ensure proper assessment and follow through was completed per facility standards. No issues with assessment were identified.** The measures put into place and systemic change made to ensure the deficient practice does not recur is: **Mandatory competency testing on proper lift procedures with return demonstration completed for all care staff. Care staff has been re-educated on following C.N.A. care sheets and in the event a change was**	

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	The nurse practitioner was called and made aware of the right leg being externally rotated out and the right leg being shorter than the other leg. An order was received for the resident to be sent to the hospital for evaluation and treatment. A nursing note dated 7/11/11 at 3:35 p.m., indicated late entry for 7/11/11 at 6:30 a.m.. The nurse arrived and received report from the night nurse that the resident fell during the night and had slight pain and received Tylenol (pain medication); The nurse did rounds and noticed resident in pain and right leg rotated outwards and painful to touch or bend. The nurse called the nurse practitioner and explained what the nurse had assessed. An order was received to send the resident to the emergency room for evaluation and treatment. A hospital History and Physical dated 7/14/11, indicated the resident was admitted on 7/11/11. The History of Present Illness: The patient "was admitted to the hospital through the Emergency Room after undergoing a fall on the evening of admission while she went to turn around and had subsequently lost her balance. The patient subsequently fell and at this time did develop a comminuted intertrochanteric fracture of the right hip (right hip fracture).		**necessary, reporting the need for a change to the nurse. Licensed staff have been re-educated on process to follow post resident fall. Education to include physical assessment, family and MD notification and immediate intervention implement towards prevention of future occurrence. A "Quick Guide to Falls" has been posted at each nurse's station as a visual reminder of this education.** To ensure the deficient practice does not recur, the monitoring system established is: **A Performance Improvement tool has been developed that will monitor that proper post fall assessments have been conducted properly in accordance with facility policy. The DNS or Designee will complete PI tools weekly for four weeks, monthly for a quarter and quarterly thereafter with results being forwarded to the PI committee for further review until 100% compliance is achieved.** **A Performance Improvement tool has been developed that will monitor C.N.A.'s use of Mechanical Lifts. The DNS or Designee will complete PI tools**	

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	A physician order dated 6/10/11, indicated the resident was to have a bed and wheelchair alarm. A care plan initiated on 7/9/11 indicated a problem of risk for falls related to requiring assistance with mobility. The approaches included, but were not limited to, a personal alarm to her bed and wheelchair. A fall assessment was completed on 6/9/11 with a score of 18 which indicated the resident was at high risk for falls. An assessment completed on 7/15/11 with a score of 15 which indicated the resident was at high risk for falls. A post fall evaluation indicated the date of the fall was 7/11/11 at 12:30 a.m. and completed by Nurse #1. The fall was unwitnessed. There was no injury noted at the time of the fall. An x-ray was ordered to rule out a fracture. The resident was rechecked and discoloration was noted to the resident's right hip. An order was received to send the resident to the hospital. The section "Intervention In Place At Time Of Fall: there was no mark in the box for alarm. The section "Footwear/Assistive Devices At Time of Fall": there was a check in the		**weekly for four weeks, monthly for a quarter and quarterly thereafter with results being forwarded to the PI committee for further review until 100% compliance is achieved.**	

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	box for shoes. The section "Location of Resident Prior to the Fall": a check was in the box for wheelchair. The immediate interventions were to toilet the resident every two hours. The Summary of Interdisciplinary Team: "to add bed alarm when back from hospital." The investigation of the fall was provided by the Administrator on 7/27/11 and reviewed at 3:00 p.m. A typed interview dated 7/13/11 with CNA #1 regarding the events of 7/11/11 and fall of Resident #H, indicated, "I had the assignment that included (Resident #H's name). At about 12:20-12:30 a.m., I noticed the door to her room was closed. When I tried to enter, I discovered the resident sitting on the floor with her back against the closed bathroom door. I called to the nurse to help. When (Nurse #1's name) came into the room, he tried to get the resident to stand up and walk to her bed, but she said, "no, "I can't stand, my leg is broken." He argued with her and said that it wasn't broken. Then we both got her into the wheelchair. I then got her to bed by standing her from the w/c (wheelchair) and quickly pivoting her on her (unaffected) leg. I remember that she was just a one-person, minimal assist on South unit-she was able to stand and walk and was almost independent			

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	155218	A. BUILDING 00 B. WING	07/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY PLACE OF DYER	2300 GREAT LAKES DRIVE DYER, IN46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	with it, so I knew she had changed. She wasn't crying, but said that it hurt really bad. I think (Nurse #1's name) gave her some medication. I went back in to check on her at (sic) at between 2:30 and 3:00, and changed her brief. She said it still hurt her, so I didn't turn her very far, but was able to get it changed. I don't remember seeing (Nurse #1's name) go back into the room during my shift." A performance Improvement Form dated 7/11/11 for Nurse #1 indicated the reason for the counseling/corrective action was the neglect to monitor resident with significant injury from fall despite giving Tylenol shortly after the fall. The documentation was inconsistent on Neuro check relative to injury sustained. The documentation was incomplete related to pain and non sequential negligence is evident. An Environmental Factors form dated 7/11/11 completed by Nurse #1, indicated the alarm was sounding, the resident's shoes were off, and both of the yes and no boxes were marked for alarm intact/battery. Interview with the Administrator on 7/28/11 at 12:30 p.m., indicated she did not know if the alarm was on when the Resident #H fell. She also indicated due			

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	to the interview with CNA #1 there was concern the resident had not been assessed prior to being moved. She further indicated CNA #2 had told management the resident had informed Nurse #1 he leg was broken prior to the resident being moved. She also indicated due to the discrepancy in the nurse's documentation it was felt the resident had not been assessed properly after the resident's fall. The nurse was terminated for this and other issues. 2. The record of Resident #E was reviewed on 7/27/11 at 2:20 p.m. The resident's diagnoses included, but was not limited to, peripheral vascular disease, diabetes mellitus, hypertension, depression disorder, cerebrovascular accident (stroke), and left below the knee amputation. A nursing note dated 7/5/11 at 6:45 a.m., indicated the CNA notified the nurse the resident was having pain in her right leg when attempting to dress her. When the resident was assessed the resident's thigh was swollen and internally rotated. At 7:45 a.m. an order was received to the resident's right hip x-rayed. At 8:00 a.m. the resident was further evaluated and sent to the hospital for evaluation and treatment.			

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	A nursing note dated 7/5/11 at 3:45 p.m., indicated staff called the hospital to check of the resident and was informed the resident was admitted with a hip fracture. A nursing note dated 7/5/11 at 6:00 p.m., indicated late entry for 7/5/11 at 8:30 a.m. The nurse was called to the resident's room to assess the resident. The resident was in bed, in no distress. Her right leg was swollen to the right thigh and internally rotated with some distortion in appearance. When her leg was moved the resident complained of severe pain. The resident was unable to move her leg unassisted and could not bend her knee. When questioned, the resident denied any recent falls or injuries. The resident indicated nothing unusual had happened to cause her to have pain in her leg. The resident's speech was clear and appropriate. She was alert and oriented times two. The nurse explained to the resident that x-rays needed to be done and she may need to be transferred to the emergency room. The resident verbalized understanding and agreed. A nursing noted dated 7/5/11 late entry, indicated at approximately 8:00 a.m. the nurse spoke with the resident regarding her injury. The resident was asked if she had fallen and if she had been transferred without the use of the hoyer lift. The			

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	resident state, "no". The resident indicated she had no pain when she was changed during the night but had pain this morning. When the resident was questions about what could have happened to cause this pain the resident stated, "I don't know, I'm so clumsy, I could have done this to myself." The resident was reassured she could talk to the nurse about any abnormal occurrences with her care without fear of retaliation and she again stated that nothing abnormal happened that she could recall. A quarterly Minimum Data Set Assessment dated 4/7/11, indicated the resident was understood and understands. She scored a 9 on the Brief Interview for Mental Status which indicated the resident was moderately impaired cognitively. A hospital History and Physical, indicated the resident was admitted on 7/5/11. The Chief Complaint: "Status post fall with right hip pain." History of Present Illness: She fell and was "brought to the hospital, was found to have a right hip fracture, which is hurting when she moves." A care plan initiated on 3/1/11, indicated a problem of resident being at risk for fall. The approaches included, but were not			

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	limited to, use hoyer/sling lift for transfers. A reportable incident with investigation was provided by the Administrator and was reviewed on 7/27/11 at 3:00 p.m., indicated "Yesterday when getting resident dressed, CNA reported that resident was complaining of pain to her right leg. Nurse assessment noted that resident's thigh was red and swollen. Nurse Practitioner ordered resident (sic) to be sent out for evaluation , where she was admitted with a hip fracture. Resident has not had any recent falls and when interviewed could not recall anything specific that happened to cause the fracture. Resident alert and oriented X's (times) 2. Investigation was immediately begun." Follow up: "All staff that cared for (Resident #E's name) 48 hours prior to her starting to complain of pain were interviewed. None reported any unusual occurrence or anything that could have contributed to the injury. When her son was called, he stated that he could see the injury being self-inflicted due to the way she holds that leg. Due to the above information, facility was unable to substantiate that this injury occurred through mistreatment or accident. An Alleged Abuse, Neglect and Exploitation Investigation Worksheet			

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	provided with the investigation, indicated CNA #4's description of incidence was at approximately 2:30 p.m. the resident was up in her wheelchair. She did not want to take a nap. After dinner at approximately 6:20 p.m. the CNA started to lay her resident's down. Resident #E was in front of the nurse's station at 7:30 p.m. The CNA asked her to start toward her room. She assisted her to her room and assisted the resident to bed in the hoyer lift. The CNA cleaned up the resident. The resident did not have swelling and did not complain of pain. Review of the staffing sheet for 7/4/11, indicated CNA #4 worked the evening shift. The Hoyer Lift Policy was provided by the Administrator on 7/27/11 at 2:50 p.m. the procedure included, but was not limited to, "Obtain assistance from another staff member for transfer." Interview with Resident #E on 7/2711 at 10:20 a.m., indicated she hurt her leg due to a fall. She further indicated she must have done it herself. She also indicated staff always use the lift to transfer her but sometime one staff member would transfer her and sometimes two staff members transfer her.			

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	Interview with Resident #E on 7/28/11 at 11:30 a.m., indicated she would tell staff if something happened. She had told someone she would not tell because she would not want to get anyone in trouble but she thought about it and now she would tell because if something happened to her it could happen to others. Interview with the Administrator on 7/28/11 at 12:30 p.m., indicated two staff members should be present during a hoyer lift transfer. She further indicated she was aware the hospital information for Resident #E indicated she had fallen. She further indicated multiple staff had spoken to her and she would not say she had fallen or anything unusual had occurred. Interview with the East Unit Manger on 7/28/11 at 1:55 p.m., indicated when the CNA #4 transferred Resident #E she did not use the assistance of another staff member. The East unit manager indicated CNA #4 had been instructed on the proper use of the hoyer lift. Interview with the Administrator on 7/28/11 at 2:00 p.m., indicated she was unaware CNA #4 had transferred Resident #E alone using the hoyer lift. The Federal tag relates to complaint IN00093712.			

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F9999	3.1-45(a)(1) STATE FINDINGS 3.1-13(g)(1)(D) ADMINISTRATION AND MANAGEMENT The administrator is responsible for the overall management of the facility but shall not function as a departmental supervisor, for example, director nursing or food service supervisor, during the same hours. the responsibilities of the administrator shall include, but are not limited to, the following: (1) Immediately informing the division by telephone, followed by written notice within twenty-four hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents, including, but not limited to any: (D) major accidents This state rule was not met as evidenced by Based on record review and interview the facility failed to report an unusual occurrence to ISDH (Indiana State Department of Health) and thoroughly	F9999	**F – 9999** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was: **Resident G no longer resides in this facility.** The corrective action taken for those residents having the potential to be affected by the same deficient practice is: **Nurse management conducted a complete facility audit of all staff reported resident events occurring in the last 30 days to ensure there were no further unusual occurrences that needed to be reported. No other issues were identified.** The measures put into place and systemic change made to ensure	08/19/2011

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	investigate the occurrence for 1 of 1 resident reviewed for unusual occurrences in a sample of 8. (Resident #G) Findings included: The record for Resident #G was reviewed on 7/28/11 at 8:00 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, renal disease, hypothyroidism, and liver failure. A nursing note dated 7/26/11 at 12:00 a.m., indicated the resident was alert and oriented to person and place. Her speech was clear, skin turgor good, and mucus membrane moist and pink. Her vital signs were temperature 97.4, pulse 80, respirations 16, blood pressure 128/50, and oxygen saturation 98%. Her AV (arterial venous) fistula (area used for dialysis) in her right arm had a palpable bruit and thrill present. Her lungs were clear. Her abdomen was soft with bowel sounds present in four quadrants. Her pulses were palpable to her extremities and no edema (swelling) was noted. The resident had no complaints of pain. There were no signs or symptoms of hyper (high) or hypo (low) glycemia (blood sugar) noted with changes in insulin orders. The resident was repositioned every two hours.		the deficient practice does not recur is: **Re-education was provided to the management staff by the district nurse consultant related to reporting unusual occurrences related to resident events. Administration shall review 24 hour reports, Complaint/Grievance forms and any staff reported resident events daily (Monday through Friday) to ensure necessary reporting is completed in a timely manner.** To ensure the deficient practice does not recur, the monitoring system established is: **A Performance Improvement tool has been developed that will monitor that unusual occurrences are reported appropriately as they occur. DNS or Designee will complete the PI tool weekly for four weeks, monthly for a quarter and quarterly thereafter with results forwarded to the PI committee ongoing for further review.**	

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	A nursing note dated 7/26/11 at 6:15 a.m., indicated her vital signs were blood pressure 173/76, pulse 71, respirations 14, temperature 98.6 and oxygen saturation 99%. Her blood sugar was 75. The resident was talking nonsense. She swallowed her medication after holding them in her mouth for several minutes. She held her arms up in the air. Her pulses were palpable in all extremities. Her extremities were dark blue in color. She denied pain. A bottle of pills were found at the bedside. The medication was Rifaximin 550 mg (milligrams). Thirteen pills remain in the bottle. Staff unsure if resident took any of the medication. At 6:40 a.m. there was no change in the resident's condition. Her speech was garbled. The nurse practitioner was called. At 8:00 a.m. nurse spoke to pharmacy and the medication, Rifaximin was an antibiotic used to treat diarrhea. The pharmacy indicated in excess it could cause confusion. At 8:45 a.m. the resident's condition continued to decline. Her mental status was declining. She was sluggish and not oriented. Her temperature was 97.4, pulse 69, respirations 16, and blood pressure 153/66. The resident's husband was notified and indicated he would come to the facility. At 8:50 a.m. the Nurse Practitioner was paged to be informed. The resident was becoming comatose.			

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	Her mental status was declining. A whole bag of medications was found in the resident's drawer including Tramadol (pain medication). The resident was unable to speak to find out where she obtained the medications. The resident's only reply was "Get out". At 9:15 a.m. the husband was at the facility and the resident did not recognize him. The resident was screaming and yelling. She had a "crazed look in her eyes." The resident's husband wanted her taken to the hospital. The facility was still waiting a return call from the Nurse Practitioner. At 9:40 a.m. there was no change in the resident's condition. The Nurse Practitioner called back and discussed case with staff. An order was received to send the resident to the hospital. 911 was called. At 9:50 a.m. the police and ambulance were at the facility. There was no change in the resident's condition. A late entry for 8:50 a.m., indicated the bag of medications found had been brought in by the resident's husband. He stated, "I wanted you to know what she was taking so I brought them in." When questioned as to why he had not given the mediations to the nurses, he indicate, "I don't know." Interview with the South Unit Manager on 7/28/11 at 8:25 a.m., indicated the resident had been admitted to the hospital with a diagnosis of acute hepatic (liver)			

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	encephalopathy. She further indicated the resident's husband had told the staff the resident had this happen in the past. He thought it was due to her missing dialysis. The Unit manager indicated the resident had not missed dialysis. AT 8:55 a.m. the South Unit Manager indicated she has spoken to the hospital and the resident had an increase ammonia level and after a couple of dialysis she was just fine. Interview with the Administrator on 7/28//11 at 12:30 p.m., indicated the occurrence had not been reported. She had not felt it was an abuse situation. She indicated the investigation completed was the husband had brought in the medications and with the initial diagnosis she did not feel any other investigation was warranted. She further indicated she did not know when the medications had been brought into the facility or how many medications were left. During the exit conference on 7/28/11 at 2:15 p.m., the South Unit Manager, indicated she did not know when the medications had been brought into the facility. She had counted the Tramadol and there were 20 tablets in the container and 90 had been dispensed but she did not know how many were brought into the facility. She did not count any of the other medications but Tramadol was the			

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	only pain medication found. 3.1-13(g)(1)(D)			